

STATE OF ILLINOIS

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Facility Name & ID Number Alden Trails# 0042051 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,422</u>			<u>5,422</u>	13
14	TOTALS	<u>5,422</u>			<u>5,422</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.59%

D. How many bed-hold days during this year were paid by Public Aid?

435 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/15/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/15/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	55,042	2,618		57,660	74	57,734		57,734			1
2	Food Purchase		16,335		16,335	(2,732)	13,603		13,603			2
3	Housekeeping	9,828	5,878		15,706		15,706		15,706			3
4	Laundry		2,026		2,026		2,026		2,026			4
5	Heat and Other Utilities			14,424	14,424		14,424	125	14,549			5
6	Maintenance			25,518	25,518		25,518	859	26,377			6
7	Other (specify):* Related party salary			80	80		80	4,331	4,411			7
8	TOTAL General Services	64,870	26,857	40,022	131,749	(2,658)	129,091	5,315	134,406			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	324,308	8,658	830	333,796	644	334,440	(781)	333,659			10
10a	Therapy											10a
11	Activities			24,097	24,097		24,097		24,097			11
12	Social Services	27,907			27,907		27,907		27,907			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Related party salary							3,239	3,239			15
16	TOTAL Health Care and Programs	352,215	8,658	28,927	389,800	644	390,444	2,458	392,902			16
	C. General Administration											
17	Administrative	12,089			12,089		12,089		12,089			17
18	Directors Fees											18
19	Professional Services			85,498	85,498		85,498	(76,919)	8,579			19
20	Dues, Fees, Subscriptions & Promotions			2,464	2,464		2,464	(594)	1,870			20
21	Clerical & General Office Expenses		2,470	6,673	9,143		9,143	3,131	12,274			21
22	Employee Benefits & Payroll Taxes			72,894	72,894	2,014	74,908		74,908			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,276	2,276		2,276	1,398	3,674			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			13,968	13,968		13,968	1,468	15,436			26
27	Other (specify):* Related party salary			18,006	18,006		18,006	19,304	37,310			27
28	TOTAL General Administration	12,089	2,470	201,779	216,338	2,014	218,352	(52,212)	166,140			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	429,174	37,985	270,728	737,887		737,887	(44,439)	693,448			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Alden Trails

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Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			13,701	13,701		13,701	32,515	46,216			30
31	Amortization of Pre-Op. & Org.							787	787			31
32	Interest			98,548	98,548		98,548	(22,979)	75,569			32
33	Real Estate Taxes							13,013	13,013			33
34	Rent-Facility & Grounds			103,704	103,704		103,704	(103,704)				34
35	Rent-Equipment & Vehicles			2,616	2,616		2,616	2,347	4,963			35
36	Other (specify):*							6,627	6,627			36
37	TOTAL Ownership			218,569	218,569		218,569	(71,394)	147,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		766	5,301	6,067		6,067	(1,475)	4,592			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,215	66,215		66,215		66,215			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		766	71,516	72,282		72,282	(1,475)	70,807			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	429,174	38,751	560,813	1,028,738		1,028,738	(117,308)	911,430			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Alden Trails

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(588)	21		17
18	Fines and Penalties	(845)	32		18
19	Entertainment				19
20	Contributions	(96)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(278)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,006)	27		24
25	Fund Raising, Advertising and Promotional	(554)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,367)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(7,338)	various	34
35	Other- Attach Schedule	(89,603)	Pg5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (96,941)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (117,308)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Trails

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fees on utilities	\$ (196)	5	1
2	Intercompany interest	(82,620)	32	2
3	Misc income	(263)	32	3
4				4
5	depreciation adjustment	(6,524)	30	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(89,603)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/04

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12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(196)	0	321	0	0	0	0	0	0	0	0	125	5
6	Maintenance	0	0	959	0	0	0	(10)	(90)	0	0	0	859	6
7	Other (specify):*	0	0	4,331	0	0	0	0	0	0	0	0	4,331	7
8	TOTAL General Services	(196)	0	5,611	0	0	0	(10)	(90)	0	0	0	5,315	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(330)	(451)	0	0	0	0	0	0	(781)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	3,239	0	0	0	0	0	0	0	0	3,239	15
16	TOTAL Health Care and Programs	0	0	3,239	(330)	(451)	0	0	0	0	0	0	2,458	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(278)	1,434	(78,075)	0	0	0	0	0	0	0	0	(76,919)	19
20	Fees, Subscriptions & Promotions	(650)	0	56	0	0	0	0	0	0	0	0	(594)	20
21	Clerical & General Office Expenses	(588)	0	3,634	70	15	0	0	0	0	0	0	3,131	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,398	0	0	0	0	0	0	0	0	1,398	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,437	31	0	0	0	0	0	0	0	0	1,468	26
27	Other (specify):*	(18,006)	0	37,271	16	23	0	0	0	0	0	0	19,304	27
28	TOTAL General Administration	(19,522)	2,871	(35,685)	86	38	0	0	0	0	0	0	(52,212)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,718)	2,871	(26,835)	(244)	(413)	0	(10)	(90)	0	0	0	(44,439)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(6,524)	28,497	9,144	0	1,398	0	0	0	0	0	0	32,515	30
31	Amortization of Pre-Op. & Org.	0	602	185	0	0	0	0	0	0	0	0	787	31
32	Interest	(83,728)	55,469	5,260	0	1	19	0	0	0	0	0	(22,979)	32
33	Real Estate Taxes	0	12,243	769	0	1	0	0	0	0	0	0	13,013	33
34	Rent-Facility & Grounds	0	(103,704)	0	0	0	0	0	0	0	0	0	(103,704)	34
35	Rent-Equipment & Vehicles	0	0	2,347	0	0	0	0	0	0	0	0	2,347	35
36	Other (specify):*	0	6,627	0	0	0	0	0	0	0	0	0	6,627	36
37	TOTAL Ownership	(90,252)	(266)	17,705	0	1,400	19	0	0	0	0	0	(71,394)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	(52)	(1,423)	0	0	0	0	0	(1,475)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	(52)	(1,423)	0	0	0	0	0	(1,475)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(109,970)	2,605	(9,130)	(244)	935	(1,404)	(10)	(90)	0	0	0	(117,308)	45

Facility Name & ID Number Alden Trails

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group,Ltd.	100	See Page 6K		See Page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Rent revenue	\$ 103,704	Alden of Bloomingdale Limited Partnership		\$	(103,704)	1
2	V	32	Revenue from investments	15,083	Alden of Bloomingdale Limited Partnership			(15,083)	2
3	V	19	Audit		Alden of Bloomingdale Limited Partnership		1,317	1,317	3
4	V	19	Misc. Admin Expense		Alden of Bloomingdale Limited Partnership		117	117	4
5	V	33	Real estate taxes		Alden of Bloomingdale Limited Partnership		12,243	12,243	5
6	V	26	Insurance expense		Alden of Bloomingdale Limited Partnership		1,437	1,437	6
7	V				Alden of Bloomingdale Limited Partnership				7
8	V	32	Interest on operating loss loan		Alden of Bloomingdale Limited Partnership		22,800	22,800	8
9	V	36	Mortgage insurnace premuim		Alden of Bloomingdale Limited Partnership		6,627	6,627	9
10	V	30	Depreciation		Alden of Bloomingdale Limited Partnership		28,497	28,497	10
11	V	31	Amortization		Alden of Bloomingdale Limited Partnership		602	602	11
12	V	32	Interest on mortgage		Alden of Bloomingdale Limited Partnership		47,752	47,752	12
13	V								13
14	Total			\$ 118,787			\$ 121,392	\$ * 2,605	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 Professional fees	\$ 79,211	Alden Management Services	0.00%	\$ 1,136	\$ (78,075)	15
16	V	21 Clerical and G & A		Alden Management Services		3,634	3,634	16
17	V	5 Utilities		Alden Management Services		321	321	17
18	V	6 Maintenance		Alden Management Services		959	959	18
19	V	24 Travel & seminar		Alden Management Services		1,398	1,398	19
20	V	26 Insurance		Alden Management Services		31	31	20
21	V	20 Dues/subscriptions/fees etc		Alden Management Services		56	56	21
22	V	30 Depreciation		Alden Management Services		9,144	9,144	22
23	V	31 Amortization		Alden Management Services		185	185	23
24	V	33 Real estate taxes		Alden Management Services		769	769	24
25	V	35 Rent-equipment/vehicles		Alden Management Services		2,347	2,347	25
26	V	32 Interest		Alden Management Services		5,260	5,260	26
27	V	7 Salaries-general serv		Alden Management Services		4,331	4,331	27
28	V	15 Salaries-health care		Alden Management Services		3,239	3,239	28
29	V	27 Salaries-general admin		Alden Management Services		37,271	37,271	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 79,211			\$ 70,081	\$ * (9,130)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	2 tube-feeding	\$	Pyramid Health Care	100.00%	\$	\$	15
16	V	10 nursing saupplies	330	Pyramid Health Care			(330)	16
17	V	39 per diems/other supplies		Pyramid Health Care				17
18	V	21 gen'l & admin		Pyramid Health Care		70	70	18
19	V	27 gen'l & admin salaries		Pyramid Health Care		16	16	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 330			\$ 86	\$ * (244)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 drugs	\$ 376	Forum Extended Care II		\$ 324	\$ (52)
16	V	10 house sock	201	Forum Extended Care II		174	(27)
17	V	39 I. V.		Forum Extended Care II			
18	V	22 employee benefits		Forum Extended Care II			
19	V	21 gen'l & admin		Forum Extended Care II		15	15
20	V	32 interest		Forum Extended Care II		1	1
21	V	33 real estate tax		Forum Extended Care II		1	1
22	V	30 depreciation		Forum Extended Care II		1,398	1,398
23	V	27 gen'l & admin salaries		Forum Extended Care II		23	23
24	V	10 Pharmacy consulting	424	Forum Extended Care II			(424)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,001			\$ 1,936	\$ * 935

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	39 therapy	\$ 5,189	Community Physical Therapy	100.00%	\$ 3,766	\$ (1,423)	15
16	V	32 interest		Community Physical Therapy		19	19	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 5,189			\$ 3,785	\$ * (1,404)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Repairs & Maintenance	\$ 6,666	Alden Bennett Construction		\$ 6,656	\$ (10)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,666			\$ 6,656	\$ * (10)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V	6 Floor Cleaning	919	Alden Realty - Floor Care		829	(90)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 919			\$ 829	\$ * (90)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 6K

Facility Name & ID Number ALDEN NURSING CENTER - TRAILS

004-2192

Report Period Beginning 01/01/04

Ending: 12/31/04

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingtondale
ANC Village for Children & Young Adults	Bloomingtondale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingtondale
Alden of Old Town West	Bloomingtondale
ANC Waterford	Aurora
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC - Governors Park	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A Schlossberg	President	Operations	100.00	226,595	0.204	0.05	salary	\$ 1,169	27-7	1
2	Lauren Magnussen	Clinical Coordinator	Nursing		73,171	0.204	0.05	salary	378	15-7	2
3	Terry Magnussen	Maintenance Supr	Maint.		49,743	0.204	0.05	salary	257	7-7	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of The Alden Goup Ltd.										6
7	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and constructon.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,804		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson Ave.
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 286-3883
 Fax Number (773) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	see page 8A...				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$			\$		1					
2	Cambridge		X		\$2,122.29	06/02		339,267		332,801	9/2037		6.8600		22,800	2			
3	Cambridge		X	Mortgage	\$6,065.97	09/03		873,700		845,590			7.9700		47,752	3			
4																4			
5																5			
	Working Capital																		
6	Related Party - AMS	X													5,260	6			
7	Related Party - FECII	X		Working Capital											1	7			
8	Related Party - Cpt														19	8			
9	TOTAL Facility Related				\$8,188.26		\$	1,212,967	\$	1,178,391			\$	75,832		9			
	B. Non-Facility Related*																		
10	Offset income with int. expense														(263)	10			
11																11			
12																12			
13																13			
14	TOTAL Non-Facility Related						\$		\$				\$	(263)		14			
15	TOTALS (line 9+line14)						\$	1,212,967	\$	1,178,391			\$	75,569		15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,627 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Alden Trails

0042051 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	12,984	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	12,660	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(324)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	12,567	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	12,243	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	13,031	8	
		2000	10,793	9	
		2001	11,137	10	
		2002	12,365	11	
		2003	12,449	12	
Accrual based on approximate 3% increase over prior year bill (\$12,660).					
		13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Alden Trails COUNTY Dupage
FACILITY IDPH LICENSE NUMBER 0042051
CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll
TELEPHONE 773-286-3883 FAX #: 773-286-3743

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet: 6,610
 B. General Construction Type:
 Exterior Brick Veneer
 Frame wood
 Number of Stories 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:
 3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>38,474</u>	<u>1995</u>	<u>\$ 147,679</u>	1
2					2
3	TOTALS	38,474		\$ 147,679	3

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	\$ 16,213	\$	22	\$		\$ 16,213	4
5	16		1997	1997	934,861	23,372	40	23,372		152,535	5
6											6
7											7
8											8
	Improvement Type**										
9	2 TV Modules			1999	1,775	177	5	177		1,775	9
10	Sprinkler System			1999	1,690	113	15	113		657	10
11	Replace heads-Irrigation system			1998	1,653	110	15	110		725	11
12	Cellozzi Ettleson - Auto Repair			2000	5,741		4			5,741	12
13	Carpentry, Ceramic,Quarry, Corain tops			2003	14,274	1,427	10	1,427			13
14										817	14
15	Panels		2003		5,175	1,035	5	1,035		2,070	15
16											16
17	X-pefit: ceiling light covers		2004		1,380	23	5	23		23	17
18	Aqua Plumbing: repair discharge line for lift station pump		2004		1,683	75	15	75		75	18
19	Alden Bennett: lift station pumps and controls		2004		4,298	191	15	191		191	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 988,744	\$ 26,523		\$ 26,523		\$ 180,823	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	12,303		15			12,303	4
5	Leasehold Improvement-Remodeling	1980	19,273		20			19,273	5
6	Leasehold Improvement-Tenant Improvement	1987	996		13			996	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,572	223	16	223		2,234	8
9	Leasehold Improvement-Build.Improv.	1996	1,259	79	16	79		704	9
10	Leasehold Improvement-Asphalting	2000	98		3			98	10
11	Leasehold Improvement-DAI	2001	172	17	10	17		54	11
12	Leasehold Improvement-Bathrooms	2002	733	82	7	82		181	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		328	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,820	148	7	148		148	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	79		23			79	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	137	27	5	27		103	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	608	7	608		1,215	28
29	Leasehold Improvement-Remodeling	2003	5,085	775	7	775		1,394	29
30									30
31									31
32									32
33		1999	13,393	266	30	266		2,041	33
34	TOTAL (lines 1 thru 33)		\$ 1,074,441	\$ 28,912		\$ 28,912		\$ 242,252	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 139,827	\$ 14,443	\$ 14,443	\$		\$ 64,269	71
72	Current Year Purchases	6,628	982	982			982	72
73	Fully Depreciated Assets	50,884	1,749	1,749			50,884	73
74								74
75	TOTALS	\$ 197,339	\$ 17,174	\$ 17,174	\$		\$ 116,135	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	dodge/other	: '98-'04	\$ 8,164	\$ 130	\$ 130	\$	3	\$ 11,658	76
77										77
78										78
79										79
80	TOTALS			\$ 8,164	\$ 130	\$ 130	\$		\$ 11,658	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,427,623	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,216	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,216	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 370,045	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$ n/a	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Hints: Of the 3 categories of input, PLUG the category that requires the most manual input. For example:
 Input Current Yr purchase section first, then the FD's (fully deprec assets), then plug the Not Fully Deprec. Section.

facility
2004 MEDICAID COST REPORT
SCH XI, SECTION C, PAGE 13
LINES 37-41

	<u>COST</u>	2004 CURRENT <u>BOOK DEPR.</u>	2004 ST LINE <u>DEPR.</u>	ADJUSTMENT, <u>IF ANY</u>	12/31/2004 ACCUM. <u>DEPR.</u>
F&F AND EQUIP. NOT FULLY DEPREC.					
<u>ON PRIOR PURCHASES</u>					
Related party-AMS	28,323.00	5,811.00	5,811.00		14,010.00
Computers	1,465.81	293.16	293.16	0.00	1,133.31
F & F	0.00	0.00	0.00	0.00	0.00
Equipment/Maj. Mov.	32,673.72	3,213.45	3,213.45	0.00	15,600.15
Partnership	77,367.52	5,125.00	5,125.00	0.00	33,525.92
Off book equip./F & F			0.00	0.00	
SUBTOTAL LINE 37	139,830.05	14,442.61	14,442.61	0.00	64,269.38
<u>ON CURRENT PURCHASES</u>					
Related party-AMS	2,268.00	734.00	734.00		734.00
Computers			0.00	0.00	
F & F			0.00	0.00	
Equipment/Maj. Mov.	4,360.18	248.28	248.28	0.00	248.28
Partnership			0.00	0.00	
Off book equip./F & F			0.00	0.00	
SUBTOTAL LINE 38	6,628.18	982.28	982.28	0.00	982.28
FULLY DEPRECIATED ASSETS					
Related party-AMS	47,882.00	1,478.00	1,478.00		47,882.00
Computers			0.00	0.00	
F & F			0.00	0.00	
Equipment/Maj. Mov.	3,001.70	271.42	271.42	0.00	3,001.70
Partnership			0.00	0.00	
Off book equip./F & F			0.00	0.00	
SUBTOTAL LINE 39	50,883.70	1,749.42	1,749.42	0.00	50,883.70
TOTAL LINE 41	197,341.93	17,174.31	17,174.31	0.00	116,135.36

TEST:
 AMOUNTS FROM SPREADSHEETS: #VALUE!
 S/B ZERO #VALUE! #VALUE! #VALUE! #VALUE! #VALUE!

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party-cost backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,616 Description: copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>patient transport</u>		\$ <u>196.00</u>	\$ <u>2,347</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>196.00</u>	\$ <u>2,347</u>	21

10. Effective dates of current rental agreement:

Beginning 01/01/98

Ending 06/01/06

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ 90,808

13. /2006 \$ 12,612

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>Skilled nurses on site</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 1,840	\$		\$ 1,840	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			917			917	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			2,544			2,544	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see page 16A	# of prescrpts				324		324	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see page 16A				(1,423)	390		(1,033)	13
14	TOTAL			\$		\$ 3,878	\$ 714		\$ 4,592	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Alden Trails

2004

Page 16
Col 5: PT,OT, & ST
Col 6: Other
Amount

XIV. SPECIAL SERVICES (Direct Cost)

Service

1. OT	39-3	\$1,840.35
2. ST	39-3	916.66
3.		
4. PT	39-3	2,543.86
5.		
6.		
7.		
8.		
9. Pharmacy		375.91
Plus: Related Party- Forum Drugs		(52.00)
Plus: Related Party- Forum I.V.		0.00
Total to line 9 Pharmacy		323.91
10.		
11.		
12. Exceptional Care-Column 3		0.00
12. Exceptional Care-Column 6		0.00
13. Other: mattress, lab, x-rays, Pyramid billings		390.00
Related Party- Pyramid		
Related Party- CPT		(1,423.00)
Total to line 13		(1,033.00)
14. Total		4,591.78

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	1,706	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 4,500)	368,394	368,394	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		4,270	6
7	Other Prepaid Expenses	814	1,924	7
8	Accounts Receivable (owners or related parties)	252,231	278,564	8
9	Other(specify):	29,515	30,767	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 650,954	\$ 685,625	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	38,487	38,487	15
16	Equipment, at Historical Cost	41,501	118,383	16
17	Accumulated Depreciation (book methods)	(35,334)	(221,185)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		22,407	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,275)	20
21	Restricted Funds		19,274	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 44,654	\$ 1,054,441	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 695,608	\$ 1,740,066	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 58,768	\$ 58,768	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,023	3,023	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,947	33,947	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,056	4,056	31
32	Accrued Real Estate Taxes(Sch.IX-B)		12,567	32
33	Accrued Interest Payable		5,861	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr.ins, exps, idpa, sales tax etc	23,692	23,692	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 123,486	\$ 141,914	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	220,020	332,801	39
40	Mortgage Payable		865,389	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 220,020	\$ 1,198,190	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 343,506	\$ 1,340,104	46
47	TOTAL EQUITY(page 18, line 24)	\$ 352,102	\$ 399,962	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 695,608	\$ 1,740,066	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 239,524	1
2	Restatements (describe):		2
3	external audit adjustments made after 2003 cost report wa	8,915	3
4	submitted.. No effect on prior years report.		4
5	Bad,medicare revenues(Non-allowables)		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 248,439	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	103,663	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 103,663	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 352,102	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,131,586	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,131,586	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vendor settlements</u>	804	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 804	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,132,401	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	131,749	31
32	Health Care	389,800	32
33	General Administration	216,338	33
	B. Capital Expense		
34	Ownership	218,569	34
	C. Ancillary Expense		
35	Special Cost Centers	6,067	35
36	Provider Participation Fee	66,215	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,028,738	40
41	Income before Income Taxes (line 30 minus line 40)**	103,663	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 103,663	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	187	200	\$ 6,012	\$ 30.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,426	1,434	37,741	26.32	3
4	Licensed Practical Nurses	2,600	2,725	54,247	19.91	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,496	2,576	27,958	10.85	14
15	Cook Helpers/Assistants	2,421	2,444	27,084	11.08	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,100	1,107	9,828	8.88	18
19	Laundry					19
20	Administrator	560	575	12,089	21.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,840	1,939	27,907	14.39	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,821	22,968	226,308	9.85	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	34,451	35,968	\$ 429,174 *	\$ 11.93	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	4,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	424	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	780	22,684	11-3	44
45	Social Service Consultant	22	1,230	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	802	\$ 28,338		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount
Randazzo/Davis	Administrator		\$ 12,089	Workers' Compensation Insurance		\$ 9,169	IDPH License Fee	\$
				Unemployment Compensation Insurance		1,623	Advertising: Employee Recruitment	267
				FICA Taxes		54,634	Health Care Worker Background Check (Indicate # of checks performed <u>4</u>)	28
				Employee Health Insurance		6,259	Related Party Ams	56
				Employee Meals		2,732		
				Illinois Municipal Retirement Fund (IMRF)*			Surety Bond fees	500
				Life and Dental,401K,nisc		76	IHCA dues	1,019
				Emp vacc,drug tests,misc costs		383		
				401K Match		33		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 12,089					
B. Administrative - Other								
Description			Amount					
			\$				Less: Public Relations Expense	(
							Non-allowable advertising	(
							Yellow page advertising	(
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 74,908	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,870
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
AMS	Management Fees		\$ 79,211					
BDO Seidman	Accounting fees		3,515				In-State Travel	
Barry Greenburg	Legal fees		2,626				Insurance and Repairs	1,106
Ken Fisch	Legal fees		77				Gasoline	1,170
Neal Gerber & Eisenberg LLP	Legal fees		70				Related Party-AMS	1,398
							Seminar Expense	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 85,498	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,674

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Alden Trails

STATE OF ILLINOIS

0042051

Report Period Beginning:

01/01/04

Ending:

Page 23

12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Healthcare Assoc \$1,019
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,948 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 66,215
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,732 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ no
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: BDO Seidman The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet available
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

**ALDEN NURSING CENTER TRAILS
EMPLOYEE MEALS RECLASS
2004 P.A. COST REPORT**

CATEGORY	BUDGET HOURS (A)		
NURSING	13		
DIETARY	2		
ACTIVITIES			
HOUSKPNG	1		
LAUNDRY			
REHAB	0		
OTHER	0		
	16 X 365=	5,840	
OFFICE	1 X 260 = (B)	260	
TOTAL EMPLOYEE MEALS		6,100	
SF&M HISTORICAL %	0.7	4,270	
RESIDENT MEALS			
CENSUS	5,857 X 3 PER DAY	17,571	
TOTAL MEALS	1.	21,841	
TOTAL FOOD EXPENSE:			
6224-100 FOOD CREDIT	(21)		
6223-100 FOOD OOB	33		
6222-100 FOOD NON-MENU	13		
6221-100 FOOD	13,950		
	2	13,975	
FOOD/MEAL RATIO	2. / 1.	0.64	
EMPLOYEE MEALS	4,270 0.64	2,732.17	
TO PG 3, COL 5, ADD TO LINE 22		Λ	
ALSO, PG 3, COL 5, DEDUCT FROM LINE 2		-----Λ	
AND, PG 23, QUESTION 15			

(A) PER PROJECTED P/R REPORT (BUDGET)
(B) 5 DAYS X 52 WEEKS

Alden Nursing Center - Alden Trails
Reporting Period Beginning
Reporting Period Ending

42051
1/01/04
12/31/04

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Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(2,732)	Employee Meal
	22	2,732	Employee Meal
22		(718)	Uniforms
	10	644	Uniforms
	6		Uniforms
	4		Uniforms
	1	74	Uniforms
	3		Uniforms
	11		Uniforms
	21		Uniforms
		<u>0</u>	Net should be 0